

# PHYSICIAN CERTIFICATION OF NEED

Dear Doctor:

To expedite the processing of request for funding of prosthetic devices for your patient, the Department of Medical Assistance Services seeks your assistance in contributing medical information so that an appropriate decision can be made promptly. Please complete the following where applicable and forward to the prosthetist for their submission with the preauthorization request form or send to Medical Support Section, Department of Medical Assistance Services, 600 East Broad Street, Suite 1300, Richmond, Virginia 23219.

1. \_\_\_\_\_  
Patient's Name
2. \_\_\_\_\_  
Medicaid Recipient I.D. Number
3. \_\_\_\_\_  
Date of Amputation
4. \_\_\_\_\_  
Date of Birth
5. \_\_\_\_\_  
Weight
6. \_\_\_\_\_  
Height
7. \_\_\_\_\_  
Diagnosis
8. \_\_\_\_\_  
Reason for Amputation
9. Are other amputations anticipated within the next twelve months?
10. If this patient has undergone a lower extremity amputation, please include the date the patient last ambulated:
11. Please list any current significant medical conditions and their present treatments, e.g. arthritis, vascular disease, neuropathy, diabetes:
12. Is the patient cognitive and physical status sufficient to enable learning the use of a prosthesis?
13. If the patient has had a prosthetic limb, why does it need to be replaced or repaired?
14. Additional medical justification for special prosthetic components, e.g. lightweight equipment, special terminal devices, modified sockets, modified feet, etc.:

## PHYSICAL EXAMINATION

15. Please indicate strength testing of all extremities, including range of motion across all joints. This should include the contralateral limb:
16. Are there any signs on examination consistent with vascular disease in the contralateral limb? Give it's present condition and viability.
17. Are there any conditions that would preclude or delay the use of prosthesis, i.e., edema, open wound, contractures or poor skin viability?

18. \_\_\_\_\_  
Physician's Name
19. \_\_\_\_\_  
Physician's Signature      Date
20. \_\_\_\_\_  
Street Address
21. \_\_\_\_\_  
Physician's Phone Number
- \_\_\_\_\_  
City, State, Zip Code